TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CY-FAIR CHIROPRACTIC ASSOCIATES

Respondent Name
METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number
M4-17-1071-02

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not include a position summary with the DWC060 request. The division will issue a decision based on the documentation contained in the dispute at the time of the review.

Amount in Dispute: $2,534.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that a large number of the charges listed on the DWC060 have either been paid at fee schedule or paid as billed. Please see Attachment 1, this attachment directs you to the EOB to review. The checks are enclosed as well in Attachment 3. Also, please note that we believe the 99215-25 on DOS 3/22/16 listed on the DWC060 should be listed as 99212-25."

Response Submitted by: STARR Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2016 through March 24, 2016	99204-25, 98940 x 4, 98943 x 4, G0283-59 x 3, 97010, 97140-59-GP x 4, 72052, 73020-59, 99212-25 x 3, 99354 x 2, 97012 x 2, 97024 x 2, and 97750-FC	$2,534.00	$110.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.204 sets out the professional medical services for division specific services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 197 – An office visit with every therapy session is not consistent with ODG recommendations for this diagnosis and therefore requires preauthorization
   - 197 – The treatment is outside of or exceeds the ODG, therefore, preauthorization is required
   - 150 – Per Medicare Therapy Services, for codes that are defined as per 15 minutes or each 15 minutes, must document actual amount of time spent on a cumulative basis for the modality. Physical Medicine rules require timed modalities be supported with time documentation. Per Medicare therapy services, documentation of each treatment shall include identification of each specific intervention/modality provided and billed for both time d and untimed codes
   - 150 – Payment adjusted because the payer deems the information submitted does not support this many services
   - 150 – Documentation submitted does not support the level of services required for an FCE. Per DWC rule 134.204 (g). FCE's shall also include the following elements...
   - 193 – Per rule 134.804, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount associated with this code may be zero. Original payment decision is being maintained

Issues

1. Did the insurance carrier issue payments for some of the disputed services rendered March 16, 2016 through March 24, 2016?
2. Is the requestor entitled to reimbursement for Codes 97024 and 97140-59 rendered on March 17, 2016?
3. Is the requestor entitled to reimbursement for CPT Code 97750-FC rendered on March 18, 2016?
4. Is the requestor entitled to reimbursement for Codes 97024 and 97140-GP-59 rendered on March 22, 2016?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for the physical therapy and office visits rendered March 16, 2016 through March 24, 2016. On April 13, 2017, Susie with the requestor's office provided an update on the disputed services identified on the DWC060 table. The following outlines the remaining disputed services:
   - Disputed services identified on theDWC060 table rendered on March 16, 2016 were paid by the insurance carrier, as a result, the requestor is no longer disputing these charges.
   - Disputed services identified on theDWC060 table rendered on March 17, 2016 were paid by the insurance carrier, with the exception of CPT Codes 97024 and 97140-59. The requestor continues to pursue dispute resolution for these services.
   - Disputed CPT Code 97750-FC rendered on March 18, 2016, was not paid by the insurance carrier. The requestor continues to pursue dispute resolution for this CPT Code.
   - Disputed services identified on theDWC060 table rendered on March 22, 2016 were paid by the insurance carrier, with the exception of CPT Codes 97024 and 97140-GP-59. The requestor continues to pursue dispute resolution for these services.
   - Disputed services identified on theDWC060 table rendered on March 24, 2016 were paid by the insurance carrier, the requestor is no longer disputing these charges.
2. The requestor seeks reimbursement for CPT Codes 97024 and 97140-59 rendered on March 17, 2016. The insurance carrier denied/reduced the disputed CPT Codes with denial reason code(s):
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 197 – The treatment is outside of or exceeds the ODG, therefore, preauthorization is required.
   - 150 – Per Medicare Therapy Services, for codes that are defined as per 15 minutes or each 15 minutes, must document actual amount of time spent on a cumulative basis for the modality. Physical Medicine rules require timed modalities be supported with time documentation. Per Medicare therapy services, documentation of each treatment shall include identification of each specific intervention/modality provided and billed for both time d and untimed codes.

28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes... (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS)... (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i) the date of injury..."

The Division finds that the disputed physical therapy services, CPT Codes 97024 and 97140-59 were rendered pursuant to 28 Texas Administrative Code 134.600 (p)(5). As a result, preauthorization was not required for the disputed services. The requestor is therefore entitled to reimbursement for these services.

Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

Procedure code 97024, service date March 17, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.06 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.06114. The practice expense (PE) RVU of 0.11 multiplied by the PE GPCI of 1.006 is 0.11066. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.18135 is multiplied by the Division conversion factor of $56.82 for a MAR of $10.30. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $7.16.

Procedure code 97140, service date March 17, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.43817. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.006 is 0.4024. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.85012 is multiplied by the Division conversion factor of $56.82 for a MAR of $48.30. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $48.30.

The Division finds that the requestor is entitled to reimbursement in the amount of $55.46 for CPT Codes, 97140-59-GP and 97024-GP rendered on March 17, 2016. Therefore this amount is recommended.

3. The requestor seeks reimbursement for CPT Code 97750-FC rendered on March 18, 2016. The insurance carrier denied/reduced the disputed CPT Code with denial reason code(s):

    - 150 – Payment adjusted because the payer deems the information submitted does not support this many services
    - 150 – Documentation submitted does not support the level of services required for an FCE. Per DWC rule 134.204 (g). FCE's shall also include the following elements...
    - 193 – Per rule 134.804, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount associated with this code may be zero. Original payment decision is being maintained.

This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204. On the disputed date of service, the requestor billed CPT code 97750-FC. The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed."

28 Texas Administrative Code 134.204 (g) states:

> The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) (1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:
>
> (1) A physical examination and neurological evaluation, which include the following:
>
> (A) appearance (observational and palpation);
>
> (B) flexibility of the extremity joint or spinal region (usually observational);
>
> (C) posture and deformities;
>
> (D) vascular integrity;
>
> (E) neurological tests to detect sensory deficit;
>
> (F) myotomal strength to detect gross motor deficit; and
>
> (G) reflexes to detect neurological reflex symmetry.
>
> (2) A physical capacity evaluation of the injured area, which includes the following:
>
> (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
>
> (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
>
> (3) Functional abilities tests, which include the following:
>
> (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
>
> (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
>
> (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
>
> (D) static positional tolerance (observational determination of tolerance for sitting or standing).

The division finds that the insurance carrier's denial is supported. The requestor's documentation does not document all the required elements when billing for a functional capacity evaluation as outlined above in 28 Texas Administrative Code 134.204(g) (1-3). As a result, reimbursement cannot be recommended for CPT Code 97750-FC rendered on March 18, 2016.

4. The requestor seeks reimbursement for CPT Codes 97024 and 97140-GP-59 rendered on March 22, 2016. The insurance carrier denied/reduced the disputed CPT Codes with denial reason code(s):

- 197 – Payment denied/reduced for absence of precertification/authorization
- 197 – The treatment is outside of or exceeds the ODG, therefore, preauthorization is required.
- 150 – Per Medicare Therapy Services, for codes that are defined as per 15 minutes or each 15 minutes, must document actual amount of time spent on a cumulative basis for the modality. Physical Medicine rules require timed modalities be supported with time documentation. Per Medicare therapy services, documentation of each treatment shall include identification of each specific intervention/modality provided and billed for both time d and untimed codes.

28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes... (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS)... (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i) the date of injury..."

The Division finds that the disputed physical therapy services, CPT Codes 97024 and 97140-59 were rendered pursuant to 28 Texas Administrative Code 134.600 (p)(5). As a result, preauthorization was not required for the disputed services. The requestor is therefore entitled to reimbursement for these services.

Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

Procedure code 97024, service date March 22, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.06 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.06114. The practice expense (PE) RVU of 0.11 multiplied by the PE GPCI of 1.006 is 0.11066. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.18135 is multiplied by the Division conversion factor of $56.82 for a MAR of $10.30. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $7.16.

Procedure code 97140, service date March 22, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.43817. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.006 is 0.4024. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.85012 is multiplied by the Division conversion factor of $56.82 for a MAR of $48.30. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $48.30.

The Division finds that the requestor is entitled to reimbursement in the amount of $55.46 for CPT Codes, 97140-59-GP and 97024-GP rendered on March 17, 2016. Therefore this amount is recommended.

5. The Division finds that the requestor is therefore entitled to additional reimbursement in the amount of $110.92, as a result this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $110.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $110.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April 20, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.